A FINAL REPORT

Medical Response to Wife Abuse in Manitoba: A Survey of Physicians' Attitudes and Practices

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INTRODUCTION

This report was commissioned by Family Dispute Services within the Department of Community Services and Corrections of the Government of Manitoba. Consistent with their policy to improve community services available to victims of abuse, the Department was interested in better understanding the present level of involvement of Manitoba physicians in this chronic and pervasive problem.

It was recognized that medical practitioners hold an important role in the detection and treatment of those suffering physical abuse. Further, it was recognized that they were a vital link in the positive coordination of community based services for battered women and their children.

This study was therefore directed to survey physicians' perceptions of the prevalence of abused women in their medical practices, to review the basic medical responses to this problem, and to assess physicians' attitudes in regard to their own preparedness to deal with situations of wife abuse.

It was determined that this study should encompass the entire Province of Manitoba and involve those physicians who are responsible for the provision of primary medical services in both urban and rural locales.

LITERATURE REVIEW

Wife Abuse: Physicians' Roles and Attitudes

Every year more women are maimed and killed by their husbands, lovers, or expartners than suffer such a fate in automobile accidents (McGoldrick, 1986). Every year many medical practitioners treat women for physical injuries and somatic complaints, the cause of which is left undetected. Every day the cycle of violence is perpetuated and at least one in ten Canadian women will be battered (MacLeod, 1980).

It is known that battered women are victims of repeated violence (Nuttall, Greaves and Lent, 1985; Straus, 1980). Statistics collected in shelters indicate that 31% were beaten weekly or daily and 26% were beaten at least once a month (MacLeod, 1980). The incidence rate for severe violence appears to be 6 per 100 couples (Straus, 1980).

Physicians hold a strategic position in the disclosure and treatment of family violence. Surveys completed to determine the level of contact physicians have with abused women have varied in their estimates but largely indicate that one in three battered women are seen at least once by a physician during their exposure to abuse (Binney, Harkell & Nixon, 1981; Pagelow, 1981; and HEW, 1980). It is clear that of the abused women who do seek medical help, few are identified as having been battered. It seems that many battered women, scarred physically and emotionally, are often silent and remain undetected during medical treatment. Interviews with physicians have revealed that half do not

view the detection and management of marital violence by physicians as "real medicine" (Borkowski, March and Walker, 1983). Traditional medical training which focuses on the management of organic disease and the dispersal of information according to subspecialities, seems to lead medical practitioners to believe that family violence is a subspeciality of psychiatry and not a daily activity of general medicine (Goodwin, 1985). It does seem that the most common response by physicians is to advise the abused woman to leave her violent husband (Johnson, 1985).

Abused women are rarely referred to other sources of help in the community by physicians (Jobling, 1974). Paradoxically, when low referral rates from physicians to other human service professionals are questioned, it seems that doctors then define marital violence within the context of their own discipline as a "medical problem" (Johnson, 1985).

Physicians hold an important position as human service professionals to have primary contact, to diagnose, and to make referrals for battered women. Yet physicians appear to identify fewer battered women than do social workers, clergy, psychiatrists or psychologists (Burris & Jaffe, 1984). Only 10 percent of the referrals in a Vancouver Transition House survey (Women's Research Council, 1980) were attributed to physicians.

Lent (1986) suggests that wife assault should be of concern to physicians because of the adverse and profound

effects it has in families. Wife battering and child abuse are linked as common aspects of family violence (Walker, 1984). There is evidence that patterns of violent behaviour are learned and are transmitted across generations (Gelles, 1972). It is clear that physicians' recognition and response to family violence has an important implication in long term, preventative health care (Lent, 1986).

Physicians may lack the time, the awareness or the interest to treat what they seem to perceive to be their patient's private affairs. While only a small proportion of doctors will draw attention to signs of possible abuse or ask in depth about how a woman was injured, others may assume she is exaggerating if she does disclose (Bowker & Mauer, 1987; Burris & Jaffe, 1984). According to the U.S. Department of Health, Education and Welfare (1980), fewer than 30 percent of the battered women surveyed indicated the medical staff asked whether they had been abused. In a survey of Canadian family physicians it was indicated that 45% had found no cases of wife battering in their practices for the year that preceded the interview. In this same study, 38% reported they never asked the patient directly about the possibility of violence (Nuttall et al., 1985).

The importance of asking directly about abuse is highlighted by a study in a New Haven medical center (Rounsaville and Weissman, 1977-78) which focused on the treatment of injuries due to wife abuse. Though women often initially gave excuses as to the cause of their injuries,

when direct inquiries were made about abuse, most disclosed the facts. Seemingly, when physicians take the time and display the interest to ask direct questions about abuse, the women who may have been abused often muster the courage to disclose.

Oglow (1985) believes it is important to start an awareness program in medical school so that young physicians will realize the importance of asking direct questions and taking an extensive trauma history of women with suspicious injuries. Though Rose and Saunders (1986) did demonstrate a relationship existed between the extent of training and beliefs about abused women, the analysis could not determine if those with sympathetic attitudes sought out training or if the training had an impact on attitudes.

Perhaps not surprisingly, it seems that female health care practitioners may have the greatest ability to detect domestic abuse and to provide the necessary supportive response (Rose and Saunders, 1986).

Thus, while battered women currently represent only a small portion of a general practitioner's caseload, it is not so small a portion as practitioners themselves believe. Because of the nature of their work as medical experts, physicians have front line contact with women who have been battered. Although physicians are not adequately trained or resourced to easily "fix" battering situations, it is clear that they do play a crucial role in the detection of abuse, in the early coordination of community based treatment

resources and in the ultimate prevention of this pervasive health problem.

METHOD

Subjects

A sampling frame was created from a listing of all Manitoba physicians who were not identified as specialists but were primarily general practitioners or family physicians. This listing was obtained from the College of Physicians and Surgeons of Manitoba and contained all physicians registered in 1987 who would meet study requirements. It was anticipated that this listing would contain a few individuals who were not appropriate: those who recently retired or left Manitoba and those who were functioning as specialists but were unable or unwilling to list themselves as consultants.

A simple random sample was drawn with a sampling ratio of 1:3. This yielded an initial study sample of 343 physicians. It was discovered that 16 of the sampled physicians were retired or no longer living in Manitoba and that 18 were actually practicing as specialists. This left a pool of 309 eligible subjects. From that pool, a total of 103 responses were obtained to the mailed questionnaire yielding a final response rate of 33%.

It should be noted that physicians are a difficult group of subjects to survey. It seems that for some topics it is particularly troublesome to maintain a high response rate. Wife abuse appears to be one of these topic areas. In a well designed and executed survey of professionals

involved in the field of domestic violence in London Ontario, it was found that physicians offered the lowest levels of response. The final overall medical response rate in that instance was 15% (Jaffe, 1988).

To maximize the response rate in this study several key steps were taken. Endorsement was obtained from the College of Physicians and Surgeons and the survey was announced in their newsletter. All correspondence with physicians was maintained through the Division of Community and Northern Medicine. Finally, once the first mailing of questionnaires was completed, telephone contacts were randomly made with possible non-respondents by fellow physicians on our research team.

The final response rate achieved was consistent across urban and rural settings. Women physicians comprised approximately 22% of the sample and represented 30% of the respondents. In statistical terms, representation of women in the sample was equivalent to gender distribution in the sampling frame (X^2=2.68, df=1, p-n.s.). Therefore, there was no bias in the sample for location of practice or gender of physician.

The Survey Questionnaire

It was established at the onset that any questionnaire that was to be completed through the mail would have to be modest in time required for completion and of immediate relevance to physicians. The target was to create a brief,

clear and balanced set of questions. A working committee, with representation from Family Dispute Services prepared a first rough draft of the survey instrument. This was circulated to medical practitioners and researchers affiliated with the Division of Community and Northern Medicine, to the College of Physicians and Surgeons, and was consequently refined by members of the research team.

RESULTS

Estimates of Prevalence in Practice

In general medical practice, in which a cross-section of the population is served, prior research would suggest, as a conservative estimate, that approximately ten to twenty percent of all adult women would be physically abused. When asked to identify the prevalence of cases of women who were physically abused in their own medical practices, half of the Manitoba physicians surveyed (54%) indicated an estimation of less than 5%. About one in four of the physicians (28%) indicated an estimation of 6 to 10% and one in five of the physicians (18%) indicated an estimate of 11 to 20%. Approximately 2% of the physicians believed that over 20% of the women in their practices were battered.

Practice prevalence estimates, generated by Manitoba physicians, were found to be significantly related to sex of physician in that men reported significantly lower rates of abuse cases seen ($t=-2.27$, $df=107$, $p<.02$). As well, number of years a physician was in practice appeared to be related to estimate of prevalence of wife abuse in that those with longer years of service tended to report low rates ($r=.-28$, $n=108$, $p<.001$). There was no relationship between location of practice (urban, rural) and estimate of prevalence of wife abuse seen in practice ($t=0.16$, $df=100$, p-n.s.).

Similarly, male physicians were significantly lower in their estimates of the frequency that abuse occurred in battering situations than were women physicians ($t=-2.70$, $df=103$, $p<.008$). As well, those in practice for longer periods of time had lower estimates of how frequently battered women they assisted in their practice were abused ($r=-.27$, $n=104$, $p<.003$).

Identification of Abused Women Contacting Physicians

When physicians were asked how often the identification of an abuse case was based on being told by the woman patient, 41% reported that this "rarely" occurred in their practice. It seems that more often abuse is identified when physicians themselves identify abuse cases and inquire about it. Physicians indicated this was the situation frequently (19%) or always (3%) in their medical practice.

Sex of physician was not related to the frequency in which women identified themselves as being abused ($t=1.43$, $df=105$, $p<.16$) or in which physicians asked about potential abuse ($t=0.51$, $df=105$, p-n.s.). There was a weak relationship between years in practice and frequency in which a physician asked about potential abuse ($r=.16$, $n=106$, $p<.05$). However, unsolicited disclosure by a woman patient was not related to the number of years her physician had been in practice ($r=.01$, $n=105$, p-n.s.).

When physical abuse was identified by a third party (other than the attending physician or the patient), most

frequently it was a friend (41%) or a family member (27%) of the patient. Seventeen percent of the physicians surveyed identified police as the most frequent third party identifying the physically abused women in their practices. This could be accounted for by police escorts to hospital.

When referral patterns were reviewed in which a third party identified an abused woman to a physician, there appeared to be differences tied to the gender of the physician. Two major referral sources were compared: professionals (that is, allied health care personnel, social workers, police) and close acquaintances of the abused women (family or friends). It was found that female doctors identified each of these two major referral categories as equivalent sources of their most frequent referrals. However, male doctors tended to identify close acquaintances of their patients as the most frequent source of their referrals on a larger scale (75%) than they identified other professionals (25%). This difference in source of most frequent referral between male and female practitioners was statistically significant ($X^2=3.84$, $df=1$, $p<.05$).

When the relationship between gender of physicians and frequency of referrals was controlled for urban/rural differences, it was found to be largely an urban phenomenon. (This may in part be explained by the lower numbers of women physicians in rural practice.) When only urban locales are considered (Brandon and Winnipeg), it appears that 45% of the women physicians had professionals serve as their major

source of referrals and 55% of the women physicians had close acquaintances of their patients serve as the primary link to first contact with the abused woman. Male practitioners had a significantly different pattern across these two major referral sources (X^2=4.27, df=1, p<.04). The bulk of male physicians (86%) identified close personal acquaintances of the abused woman as their major referral source. Only a small proportion (14%) of the male physicians reported other professionals as the most frequent source of contact with battered women.

Recent Contact With Abused Women

Physicians were asked how many adult female patients had been identified in their own practice as being abused by their partners in the past three months. Thirty percent of the respondents indicated that none had been identified.

Of those physicians that had treated an abused woman in the past three months, it was found that on average 3.6 women were seen over this time period (s.d=3.4).

Those physicians that had never treated an abused woman in the past three months, tended to be male practitioners (X^2=3.83, df=1, p<.05) and those that had been in practice for longer periods of time (X^2=7.75, df=2, p<.02). It was found that 15% of female physicians as compared to 36% of the male physicians had not identified any abused women in their practices over the past three months.

Eighty-four percent of the physicians who had been in practice one to three years had identified abused women in their practice within the past three months. This dropped to 74% in physicians who had practiced for four to nine years. This further dropped to 55% in physicians who had practiced for ten or more years.

When asked how often physicians fail to detect signs and symptoms of abuse in their adult female patients, 73% of doctors surveyed indicated this occurred "frequently", 22% indicated "sometimes" and 5% indicated "rarely".

Physicians' Response to Identified Cases of Wife Abuse

Physicians were asked to report their pattern of response to cases of wife abuse they had identified in the past year. A few of the general practitioners and family physicians had not seen a case in the past year (6%).

The most frequent response by a physician is that they themselves would provide counselling to the abused woman (72%). Sixteen percent counselled both the husband and abused wife.

A third of the physicians (31%) indicated that they could only respond to the medical problems because most often counselling was refused. Twenty-one percent of the physicians encouraged couples to sort out problems themselves.

These described patterns of treatment were found to be consistent across gender and years of practice in survey

respondents. However, there was some difference found when rural and urban practitioners were compared. These are outlined in Table 1.

TABLE 1

TREATMENT AND REFERRAL PATTERNS OF PHYSICIANS WHO HAVE IDENTIFIED PHYSICAL ABUSE IN PAST YEAR:

Response	Urban	Rural
Treatment:		
Counsel Victim*	79%	57%
Counsel Partners	15%	11%
Encourage Partners	21%	20%
Only Physical Care	30%	37%

(*X^2 significant at $p<.05$)

The only difference that reached statistical significance in comparing treatment responses was the provision of counselling to the victim of abuse. Urban physicians were more likely to offer this to their patients than were rural physicians.

Continuing Education and In-Service Training in Wife Abuse

When asked whether they had attended any workshops or seminars in the past five years, which dealt with detection and management of wife abuse or family violence, 64% of the

physicians stated they had not. When the reason for non-attendance was explored, 72% indicated that courses were not available and they could therefore not access such educational resources. However, 58% of those who were not involved in any workshops or seminars indicated this subject area was not viewed by them in the past as a priority for workshop or seminar attendance.

When asked whether they had read any books or articles in regard to the medical role in the detection and treatment of wife abuse, in the past year, 85% stated they had done so. Of those who had not read any related material, 31% believed it was unavailable and 57% indicated this topic was not a priority for them.

It was found that physicians who had attended a workshop or seminar, within the past five years, had significantly higher levels of case identification of abused women ($t=-2.69$, $df=59.4$, $p<.009$) and asked more direct questions about it when treating adult women ($t=-2.08$, $df=105$, $p<.04$), than did their colleagues who had never attended a workshop or seminar

Sixty-nine percent of the physicians surveyed "agreed" or "strongly agreed" that they need information from a medical perspective, regarding the identification, treatment and referral of wife abuse cases. Almost every physician contacted (91%) felt they could immediately benefit from more written material on this subject.

Almost three quarters (73%) of the physicians felt they could presently benefit from workshop and seminar opportunities related to the medical aspects of the detection and treatment of wife abuse. It was found that women physicians tended to be more interested (94%) than were their male colleagues (63%) in seminar attendance (X^2=8.36, df=1, p<.004). Although rural doctors expressed less interest (63%) than did their urban colleagues (79%) in seminars or workshops, this difference was not strong enough to reach statistical significance (X^2=1.79, df=1, p-n.s.).

DISCUSSION

It would appear that Manitoba physicians tend to underestimate the occurrence of wife abuse across the patient populations of adult women they serve.

Some medical practices will contain women that are not representative of a cross-section of women in the general population. Some physicians will serve patient groups in which the victims of family violence will not frequently appear in their offices. However, most doctors will provide primary medical care to a wide range of women and will not become involved in wife battering. It is known that wife abuse occurs across all socio-economic strata and across Canadian cultural groups. There is evidence that the medical response is limited and does not reach many women in need). This survey of Manitoba doctors therefore has yielded results that are consistent with prior research which has studied the medical involvement in the detection and treatment of battered women.

However, this research has suggested that a closer look at physicians' activities does yield some promising findings. First, it does appear that younger physicians with more recent training are more aware of abused women in their practices, tend to ask about it more often and tend to treat it more frequently.

Further, the increasing presence of women, in the ranks of general and family practitioners, has appeared to have heightened the medical response to wife abuse. Women

physicians tend to more frequently treat battered women. They appear to be more closely aware of its prevalence and severity in the communities they serve. However, it does not appear that actual treatment methods differ significantly between male and female physicians, when medical services are delivered to battered women.

It is clear that much work remains to be done to heighten the medical involvement in the detection and treatment of wife abuse. It is significant that one in three of all general practitioners and family physicians did not have contact with one battered woman over (at least) the three months preceding the date of the survey. Even those that did have contact with such a case over the three month period only assisted, on average, one abused woman per month. It would appear that many women suffering abuse bypass the medical system entirely or pass through for treatment of their physical injuries but are not detected as abuse cases.

It did seem that women were more likely to discuss abuse when asked directly about it rather than when left to disclose the situation without being questioned. Unfortunately, it does seem that physicians tend to rely on self disclosure in their women patients. This tendency appeared to exist across all groupings of physicians whether male or female, whether new to practice or a seasoned caregiver.

Physicians themselves recognize that frequently they fail to detect the signs and symptoms of physical abuse in adult women. Part of this circumstance may be the questioning of whether it is appropriate for medical practitioners to become directly involved in domestic disputes. Part of this circumstance may be that they are not adequately trained to detect, treat or make appropriate referrals to community resources.

It does appear that for the low numbers of cases that are detected, most physicians do offer counselling to the victim of abuse. In a small proportion of these instances, the counselling also involves the abusing partner.

It is of note that one third of the physicians reported that in most of their contacts with abused women they found that they could only respond to medical problems because their offer of counselling was refused. One in five of the physicians most often saw the best course of action to follow would be to encourage the abused woman and her partner to straighten out their domestic problems on their own. These are strong signals that the existing medical response might be strengthened through close coordination with existing community services when cases of wife abuse are detected by physicians.

Although the findings of this survey in regard to referral patterns to physicians remain inconclusive, there were some intriguing leads in the information collected. At this time, it seems that many women receive attention from

medical practitioners through third party referrals. These most commonly appear to be family members or friends of the abused women. A small cohort of physicians identify the police as their most frequent referral source. There seems to be a differential pattern in this regard between male and female physicians practicing in urban Manitoba locales. In the city it seems that professional referrals are most often made to female doctors.

The information available through this brief survey was insufficient to describe this referral pattern in detail. It does however suggest that there may be some features of female doctors which makes them more receptive for such referrals or there may be an attitude existing in the human service professional community that women physicians are more "appropriate" to provide service to battered women. However, our findings suggest that battered women themselves will disclose and seek treatment from physicians they trust independent of the physician's gender.

The survey findings do suggest that there is a need in Manitoba for continuing education to better prepare physicians in general and family practice to identify and respond to their adult female patients who have been physically abused by their spouse. Physicians themselves appreciate the need for more information which offers a medical perspective on the detection, treatment and referral of battered women. Almost every physician surveyed was interested in more written material and almost three

quarters felt they could immediately benefit from workshop or seminar opportunities. An important finding of this survey was that those doctors who had recently attended such a workshop or seminar did consequently identify significantly higher numbers of abused women in their medical practices. This suggests that when such educational opportunities are made available they may serve to improve the medical response to abused women.

RECOMMENDATIONS

1. It is unfortunate that wife abuse is generally viewed as a "womens' issue" rather than a "human problem". Professionals in the human services need to dispel this myth in the public and certainly not perpetuate it through their referral and treatment practices. Action needs to be taken to change prevailing professional attitudes. This might be done through special efforts such as advertisements in professional newsletters and journals to challenge human service professionals apparent attitude that: (a) battered women do not represent a serious health problem, and; (b) that they are best handled by other women for what are basically "womens' concerns".

2. The detection issue is a critical one. It appears that if physicians directly ask about potential physical abuse, disclosure will be higher and treatment more frequent. Physicians need special encouragement to be more vigilant for domestic violence and to take responsibility for practice detection of cases of wife abuse.

3. Physicians are most open to and interested in written materials to facilitate their treatment of abused women. A special series of brochures needs to be designed and distributed with a medical perspective on wife abuse. These should be as detailed and specific as possible in regard to recommended detection, intervention and referral procedures. Basic information should be readily available that could better inform physicians about the prevalence of wife abuse and the devastating health consequences of family violence.

4. There appears to be a heightened receptivity in more recently graduated physicians to deal with these serious health care problem. This receptivity should be encouraged and used a foundation for more extensive involvement of physicians over the long term for the detection and treatment of wife abuse. Effort should be made for more focused training opportunities for physicians. The optimal time to introduce such training appears to be within the basic study period in medical school or shortly after completion of the medical degree.

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